STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297124	A. BUILDING _____ B. WING _____	C 07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE HOME HEALTH AGENCY	2780 S JONES STE B LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This Statement of deficiencies was generated as a result of the Medicare recertification survey conducted at your agency on July 24 through July 25, 2008. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The active census at the time of the survey was 55. 16 clinical records were reviewed. 4 home visits were conducted. The following complaint was investigated and found to be unsubstantiated. CPT #NV18548- unsubstantiated The following regulatory deficiencies were identified:	G 000	The agency does not dispute the findings of the survey team. The deficient practices identified by the survey team and stated in this Statement of Deficiencies had previously been identified by the Quality Assurance/Performance Improvement Department. This is evidenced by the quarterly clinical record reviews for 3rd & 4th quarter 2007, 1st & 2nd quarters of 2008 and the annual program evaluation. This documentation was reviewed by the survey team at the time of the survey. Plans of action related to these deficiencies were instituted immediately after the conclusion of the survey and will continue to be areas of focus for 3rd & 4th quarters 2008.	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure the care followed a written plan of care established by the physician for 5 of 16 patients in the sample (#4, #6, #11, #13, #14).	G 158	**G 158** *Corrective action for patients affected by the deficient practice.* The agency is unable to correct the deficient practice for Patients #4, #6, #11, #14 as these patients have been discharged from the agency. Patient #13 - Visits were conducted the week as per the plan of care for the weeks beginning 6/29/08 and 7/8/08. (Attachment M1)	

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BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 12/2/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 158	Continued From page 1 Findings include: Patient #4 Patient #4 was admitted on 7/10/08 with the following diagnoses Diabetes Mellitus, Hypertension, and Renal Failure. Record Review 1. The start of care, dated 7/10/08 through 9/7/08 stated: "SN (skilled nurse) frequency: 2 times a day for 60 days. SN to assess endocrine status related to diabetes mellitus- check blood sugar every visit, signs and symptoms of hypo/ hyperglycemia, knowledge of disease process and compliance to diabetic regime; assess patient/ caregiver's ability/ competence to do blood sugar checking and insulin administration." 2. On 7/11/08, there was no documented evidence to verify the skilled nurse conducted two home visits as ordered by the physician. 3. During 7/14/08 through 7/20/08, there was no documented evidence to verify the skilled nurse conducted two home visits as ordered by the physician. Interview On 7/24/08, the Director of Nursing revealed agency staff were directed to have the skilled nursing visit notes in the office on the Monday of the next week. The agency was unable to provide evidence the visits were conducted as per the physician's orders.	G 158	Other patients having the potential to be affected by The deficient practice. All patients have the potential to be affected by this deficient practice. Measures or systemic changes instituted to ensure the deficient practice will no/recur. All staff have received in depth in-service education, 1:1 counseling, copies of the nurse practice act and newsletters addressing adherence to the plan of care, (Attachment M-2) The RN's have received instruction regarding completion of the initial assessment. The assessment must lead to a plan of care that reflects the actual needs of the patient and not a textbook plan of care related to the disease process. (Attachment M-3) All staff will submit their patient schedules every Friday. The DPS (Director of Professional Services) will review the schedules to ensure that the visit frequency matches the plan of care. All disciplines are to submit visit notes every Monday. Medical records staff will input documentation into visit track. Medical records will notice the administrator or DPS of any visit discrepancies or missing notes weekly. The DPS will follow-up with the appropriate discipline to ensure visit notes are submitted timely. The QA/PI (Quality Assurance/Performance Improvement) Department will review all notes and compare the documentation to the	

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G 158	Continued From page 2 Patient #6 The patient was admitted on 6/3/08 with the following diagnoses: Hypertension, Congestive Heart Failure, Fracture of Distal Ulna, Abnormality of Gait and Alzheimer's Disease. Record Review On 6/16/08, the physician's order stated: "Patient has redness at the coccyx area. Skilled Nurse cleansed using aseptic technique with normal saline, pat dry, apply zinc oxide ointment, cover with dry sterile dressing, secure with tape." On 6/25/08 and 6/27/08, the licensed nurse documented: "cleanse with normal saline, pat dry, apply Siver (Silver?) Sulfa 1% cover with dry sterile dressing and secure with tape." The licensed nurse failed to ensure the wound treatment administered to the patient followed the physician's order. Patient #11 The patient was admitted on 6/4/08 with the following diagnoses: Dizziness and Giddiness, Abnormality of Gait, Diabetes Mellitus, Hypertension and Coronary Atherosclerosis. Record Review Physician's orders, dated 6/4/08 through 8/2/08 indicated: "SN (skilled nurse) frequency: 3 times a week for 2 weeks; 2 times a week for 2 weeks and 1 time a week for 5 weeks." On 7/25/08, the weekly nursing home visits ordered by the physician were not available for	G 158	patient's plan of care/physician's orders. The QAIPI department will also ensure the clinical record contains physician's orders have been obtained for all treatments administered. *Monitoring of corrective action.* The QA/PI department will continue to monitor all clinical notes for adherence to the plan of care. In-service education and 1:1 counseling will continue. *Responsible Party for monitoring compliance* While the QA/PI Department will have primary responsibility for monitoring adherence to the plan of care, The DPS will have ultimate responsibility to ensure all staff provide care in accordance with the plan of care. Date of completion 12/2 /08	

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G 158	Continued From page 3 review from 6/30/08 through the week ending 7/19/08. Patient #13 The patient was admitted on 11/12/07 with the following diagnoses: Malaise and Fatigue, Open Reduction Femur, Obstructive Chronic Bronchitis, Abnormality of Gait, Diabetes Mellitus and Hypertension. Record Review 1. The physician's order dated 5/10/08 through 7/8/08, stated: "SN (skilled nurse) frequency: 2 times a week for 4 weeks; 1 time a week for 5 weeks; CNA (certified nursing aide) order: 2 times a week for 4 weeks; 1 time a week for 5 weeks for personal care/ hygiene, activities of daily living assistance and other assigned tasks as per certified home health aide standard." The CNA conducted three home visits during the weeks beginning 5/25/08, 6/1/08 and 6/8/08, not two home visits as ordered by the physician. The CNA conducted two home visits during the weeks beginning 6/15/08, 6/22/08 and 6/29/08, not one home visit as ordered by the physician. The licensed nurse conducted an extra home visit during the week beginning 6/8/08, not one as ordered by the physician. There was no documented evidence the licensed nurse conducted home visits during the weeks beginning 6/29/08 through the end of the recertification period on 7/8/08.	G 158		

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G 158	Continued From page 4 2. The physician's order dated 7/9/08 through 9/6/08, stated: "SN (skilled nurse) frequency: 2 times a week for 3 weeks; 1 time a week for 6 weeks." There was no documented evidence to verify the licensed nurse conducted two home visits during the first two weeks of the recertification period starting 7/9/08. Patient #14 The patient was admitted on 7/12/08 with the following diagnoses: Coronary Artery Disease, Malaise and Fatigue, Long-term Use Anticoagulant, Hypertension and Gouty Arthropathy. The physician's order dated 7/12/08 through 9/9/08, stated: "SN (skilled nurse) frequency: 1 time a week for 1 week, 3 times a week for 2 weeks, 2 times a week for 3 weeks; 1 time a week for 3 weeks. Skilled assessment: SN to assess incision site on left groin status post angiogram, observe for increased bruising, any drainage, signs and symptoms of infection, sensation on affected extremity, pain status." On 7/15/08 and 7/17/08, the licensed nurse conducted home visits. The skilled nurse documented skin intact. The section for assessment of the incision and bruises were not completed by the skilled nurse. There was no documented evidence to verify the licensed nurse assessed the incision site on left groin status post angiogram, observed for increased bruising, any drainage, signs and symptoms of infection, and sensation on affected	G 158		

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G 158	Continued From page 5 extremity.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on interview and record review, the plan of care failed to include instructions for timely discharge for 1 of 16 patients (#13). Findings include: Patient #13 The patient was admitted on 11/12/07 with the following diagnoses: Malaise and Fatigue, Open Reduction Femur, Obstructive Chronic Bronchitis, Abnormality of Gait, Diabetes Mellitus and Hypertension. Record Review Patient #13 had received home health services since 11/12/07. 1. The Plan of Care for the recertification period, dated 5/10/08 through 7/8/08 stated: "SN (skilled nurse) frequency: 2 times a week for 4 weeks; 1 time a week for 5 weeks; CNA (certified nursing	G 159	**G 159** *Corrective action for patients affected by the deficient practice.* Patient #13 - See (Attachment M-4) regarding the current status of the patient. *Other patients having the potential to be affected by the deficient practice.* All patients have the potential to be affected by this deficient practice. Measures or systemic changes instituted to ensure the deficient practice will not recur. Case conferences are conducted weekly. Staff has been instructed that discharge planning must begin at the time of the initial assessment. Staff must provide a skilled service to the patient at each visit and will document the patient's progress towards goals in measurable terms. The RN will assess the patient and in consultation with the physician, determine if skilled services are to continue (See 164). Documentation in clinical notes must reflect the skilled service provided and determination of continuation of care shall be based on this documentation, not just the verbal report of the staff. When skilled services are no longer required, the patient must be discharged from the agency. *Monitoring of corrective action.* The QA/PI department will review clinical notes to ascertain if clinical notes support the need for skilled	

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G 159	Continued From page 6 aide) order: 2 times a week for 4 weeks; 1 time a week for 5 weeks for personal care/ hygiene, activities of daily living assistance and other assigned tasks as per certified home health aide standard." The 60 day summary for the recertification period stated "Patient continues to have altered respiratory status with poor endurance, needs moderate to maximum assist with activities of daily living, dependent on oxygen during the day and night; Patient is mainly wheelchair bound, uses walker occasionally to go to the bathroom with assistance and supervision, high risk for falls and potential diseases complications." 2. The physician's order dated 7/9/08 through 9/6/08, stated: "SN (skilled nurse) frequency: 2 times a week for 3 weeks; 1 time a week for 6 weeks. CNA (certified nurse aide) order: 2 times a week for 4 weeks; 1 time a week for 5 weeks." The 60 day summary for the recertification period stated "Patient continues to have generalized weakness and altered respiratory status with a history of falling recently; patient continues to need moderate to maximum assist with ADL's (activities of daily living), dependent on oxygen during the day and night; Patient is mainly wheelchair bound, elderly spouse; continues to be high risk for falls and potential disease complications." Interview During a home visit on 7/25/08, the patient and the spouse indicated the home health staff had not discussed a plan for discharge from home health services since the start of care.	G 159	services, the patient's comprehension of instructions, progress toward identified goals, and progress towards discharge. The QA/PI representative will attend all case conferences to provide this information. *Responsible Party for monitoring compliance* The QA/PI Department and DPS will have primary responsibility for monitoring documentation to ensure skilled services are provided and discharge planning is initiated. The administrator will have ultimate responsibility to ensure all staff provide skilled services and discharge planning. Date of completion 12/2 /08	

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G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on record review, the agency staff failed to alert the physician to changes in the patient's condition which suggested a need to alter the plan of care for 1 of 16 sampled patients (#2). Findings include: Patient #2 Patient #2 was a 78 year old female admitted on 2/21/08. The diagnoses were Chronic Kidney Disease, Anemia, Diabetes Mellitus, Coronary Atherosclerosis and Hypertension. Record Review Physician's orders dated 2/21/08, stated: "SN (skilled nurse) frequency: 2 times a week for 2 weeks; 1 time a week for 7 weeks. Skilled Assessment: SN to notify MD (doctor) for temperature over 101 degrees Fahrenheit; SBP (systolic blood pressure under 90 and over 160 mmHg (millimeters mercury); BS (blood sugar under 60 mg/dl and over 250mg/dl; No response /adverse response to medications and treatment; Early signs and symptoms of infection; fall / injury." On 3/14/08, the licensed nurse documented: "Hypoglycemic event. Patient reported continued occurrence with hypoglycemia. Mostly	G 164	**G164** *Corrective action for patients affected by the deficient practice.* The agency is unable to correct the deficient practice for Patient #2 as the patient has been discharged from the agency. *Other patients having the potential to be affected by the deficient practice.* All patients have the potential to be affected by this deficient practice. *Measures or systemic changes instituted to ensure the deficient practice will not recur.* Staff was in-serviced regarding the Nevada Nurse Practice Act and Medicare regulatory requirements. Staff was instructed that providing any treatments or care without a physician's order was practicing outside their scope of practice a violation of the Nurse Practice Act and the regulatory requirements. Staff was also instructed that Physician's are to be notified of any changes in condition, vital signs below parameters, blood sugar results outside of stated parameters, changes in wound status, cognitive status or ambulation. All contacts with the physician are to be documented by the person contacting the physician. Documentation is to be specific. Name of MD, date, time of call, what you told the physician and the physician's response is also to be documented. If staff members leaves a message and does not receive a	

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G 164	Continued From page 8 ____(unable to read) episode during early mornings with blood sugars between 40-49 on some days (unable to read). On 3/20/08, the licensed nurse documented: "Patient reported hypoglycemia at 1200 midnight with blood sugar read 64 went to drink purple juice at this time blood sugar 163. " On 3/27/08, the patient was transferred to a local hospital. A physician's order for resumption of care was initiated on 4/3/08. The physician's order dated 4/3/08, indicated the patient was now on insulin injections. The record lacked documented evidence the skilled nurse alerted the physician regarding the two hypoglycemic episodes reported by the patient.	G 164	Return call from the physician, the staff member wilt follow-up with the next day. (Attachment M-2) As this requirement coincides with G158 and GI 59, please see corrective action at these tags. *Monitoring of corrective action.* All clinical notes will be reviewed by the QA/PI department to ensure staff has notified the physician of any changes in the patient's condition. *Responsible Party for monitoring compliance* The DPS will be ultimately responsible to ensure compliance Date of completion 12/2 /08	
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on interview and record review, agency staff failed to administer drugs and treatments only as ordered by the physician for 4 of 16 sampled patients (#1, #2, #6, #16). Findings include: Patient #1 Patient #1 was an 87 year old male admitted 9/4/07. The diagnoses were Abnormality of Gait, Alzheimer's Disease, Open Wound of Elbow, and	G 165	**G 165** *Corrective action for patients affected by the deficient practice.* The agency is unable to correct the deficient practice for Patients #1, #2, #6, #16 as these patients have been discharged from the agency. *Other patients having the potential to be affected by the deficient practice.* All patients have the potential to be affected by this deficient practice. Measures or systemic changes instituted to ensure the deficient practice will not recur. Staff was in-serviced regarding the Nevada Nurse Practice Act and Medicare regulatory requirements. . Staff was instructed that providing any treatments	

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G 165	Continued From page 9 Lumbago. Record Review On 9/4/07, the licensed nurse documented: "a skin tear located on the left elbow measured 4 cm (centimeters) by 0.5 cm by 0." The licensed nurse documented: "wound cleansed with soap and water and apply Neosporin ointment and cover with dry 4x4 and tape daily." The family returned demonstration for the treatment of the wound satisfactory. The record lacked documented evidence a physician's order was obtained for wound care. Patient #2 Patient #2 was a 78 year old female admitted 2/21/08. The diagnoses were Chronic Kidney Disease, Anemia, Diabetes Mellitus, Coronary Atherosclerosis and Hypertension. Record Review The plan of treatment dated 2/21/08, listed the following medications: "Glimepiride 2mg. (milligrams) one tablet by mouth two time a day." The patient was on a no concentrated sugar, low fat, low salt, low cholesterol diet. On 3/27/08, the patient was transferred to a local hospital. A physician's order for resumption of care was initiated on 4/3/08. The physician's order dated 4/3/08, indicated: "the patient was now on insulin injections and an 1800 calorie ADA (American Diabetic Association), low salt. low fat, and low cholesterol diet."	G 165	or care without a physician's order was practicing outside their scope of practice a violation of the Nurse Practice Act and the regulatory requirements. When the patient requires therapy services, the admitting RN will obtain a physician's order for an evaluation by the therapist. The DPS will ensure a physician's order has been written and will give report to the therapist including but not limited to, diagnosis, demographic information, ordering physician and treatment required. The DPS will ascertain from the therapist the date and approximate time the therapist will conduct the initial evaluation, ensuring that the evaluation will be conducted within 72 hours of the start of care. This information will be documented on the therapy referral form. These corrective actions are in conjunction with the corrective actions identified at G158 and G164, *Monitoring of corrective action.* The QA/PI department will continue to monitor all clinical notes for adherence to the plan of care and appropriate physician's orders for any new/changed medications or treatments. In-service education and 1:1 counseling will continue.	

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G 165	Continued From page 10 On 4/3/08, the licensed nurse documented: "Patient given teaching on proper technique of giving Insulin injection and also proper sharp disposal." On 4/10/08, the licensed nurse documented: "Lantus 10 units every morning. New medication that may result hypoglycemia reaction; signs and symptoms cold clammy sweat, lightheadedness lethargic effect." The record lacked documented evidence a physician's order for Insulin was obtained. Patient #6 The patient was admitted on 6/3/08 with the following diagnoses: Hypertension, Congestive Heart Failure, Fracture Distal Ulna, Abnormality of Gait and Alzheimer's Disease. Record Review The physician's orders dated 6/3/08 through 8/12/08, indicated: "OT (Occupational Therapy) evaluation." There was no documented evidence to verify the occupational therapist conducted an OT evaluation as ordered by the physician. Interview On 7/24/08, the Director of Nursing was unable to verify an OT evaluation was conducted. Patient #16 The patient was admitted on 6/13/08 with the following diagnoses Drug Dependency, Anxiety	G 165	*Responsible Party for monitoring compliance* The QA/PI Department will have primary responsibility for monitoring adherence to this action plan. The DPS will have ultimate responsibility to ensure this regulatory requirement is met Date of completion 12/2 /08	

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G 165	Continued From page 11 State, Schizophrenia, Digestive Neoplasm and Hypertension. Record Review The physician's order dated 6/13/08 through 8/11/08, stated: "Skilled Nurse frequency 2 times a week for 4 weeks; 1 times a week for 6 weeks." On 6/18/08, the physical therapist conducted a physical therapy evaluation with a recommendation to treat the patient 2 times a week for 5 weeks. The physical therapist conducted a physical therapy evaluation without a physician's order. Interview On 6/25/08, the Director of Nursing did not find a physicians's order for the physical therapy evaluation.	G 165		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on record review, the registered nurse failed to re-evaluate the patient's nursing needs for 1 of 16 sampled patients (#1). Findings include: Patient #1 Patient #1 was an 87 year old male admitted 9/4/07. The diagnoses were Abnormality of Gait,	G 172	**G 172** *Corrective action for patients affected by the deficient practice.* The agency is unable to correct the deficient practice for Patients #1 this patient has been discharged from the agency. *Other patients having the potential to be affected by the deficient practice.* All patients have the potential to be affected by this deficient practice. Measures or systemic changes instituted to ensure the deficient practice will not recur. As this deficient practice coincides with the deficient practices identified at G 158, G 159, G 164, and G 165, the corrective action stated	

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	297124	A. BUILDING _____ B. WING _____	C 07/25/2008

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G 172	Continued From page 12 Alzheimer's Disease, Open Wound of Elbow, and Lumbago. Record Review The physician's order dated 9/4/07, stated:" SN (skilled nurse) frequency 2 times a week for 2 weeks; 1 time a week for 7 weeks." On 9/4/07, the licensed nurse documented: "a skin tear located on the left elbow measured 4 cm (centimeters) by .5 cm by 0." The licensed nurse documented: "wound cleansed with soap and water and apply Neosporin ointment and cover with dry 4x4 and tape daily." The family returned demonstration for the treatment of the wound satisfactorily. On 9/10/07 and 9/14/07, the licensed nurse indicated the wound located on the left elbow was healing and the treatment was done by the spouse. On 9/28/07, the patient was transferred to an assisted living facility. On 10/10/07, the licensed nurse indicated the patient had decreased mobility and refused to ambulate. On 10/18/07, the licensed nurse documented the patient had a decubitus ulcer located on the left heel which measured 5cm (centimeters) by 5.5 cm by 0.1 cm with a small amount of bloody drainage. The skilled nurse failed to assess the skin tear located on the left elbow.	G 172	at those tags will also apply to G 172. Staff has been instructed that even when family members assume care of the wound, the nurse is still responsible for assessing the status of the wound at each visit and notifying the physician of any changes that may necessitate a change in the treatment plan. *Monitoring of corrective action.* The QA/PI staff will review all clinical notes to ensure staff has assessed any changes to the patient's wounds or other changes in condition. *Responsible Party for monitoring compliance* The QA/PI Department will have primary responsibility for monitoring adherence to this action plan. The DPS will have ultimate responsibility to ensure this regulatory requirement is met Date of completion 12/2 /08	
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.	G 229	**G229** *Corrective action for patients affected by the deficient practice.* Home Health Aide supervisory visits have been conducted	

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G 229	Continued From page 13 This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure supervisory visits of the home health aides were conducted every 14 days for 1 sampled patient (#13) . Findings include: Patient #13 The patient was admitted on 11/12/07 with the following diagnoses: Malaise and Fatigue, Open Reduction Femur, Obstructive Chronic Bronchitis, Abnormality of Gait, Diabetes Mellitus and Hypertension. Record Review The physician's order dated 5/10/08 through 7/8/08, stated: "CNA (certified nursing aide/home health aide) order: 2 times a week for 4 weeks; 1 time a week for 5 weeks for personal care/ hygiene, activities of daily living assistance and other assigned tasks as per certified home health aide standard." The last documented supervisory visit was conducted on 5/26/08. There was no documented evidence to verify the skilled nurse conducted on-site supervisory visit no less frequently than every 2 weeks.	G 229	every two weeks since the survey for Patient #13.(Attachment M-6) Other patients ha ping the potential to be affected by the deficient practice. All patients have the potential to be affected by this deficient practice. Measures or systemic changes instituted to ensure the deficient practice will not recur. This regulatory requirement has been reviewed with staff as well as their responsibility to supervise the home health aide as stated in the Nurse Practice Act. When patients are receiving the services of a home health aide~ the case managers will identify on their weekly schedule when supervisory visits are to be conducted. Medical records staff will input documentation into visit track. Medical records will notify the administrator or DPS of any visit discrepancies or missing supervisory visits weekly. (SEE ATTACHED)	
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse	G 337	**G 337** *Corrective action for patients affected by the deficient practice.* Patient #4 and Patient #13 are the only active patients currently receiving care	

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G 337	Continued From page 14 effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure comprehensive assessments included a review of all medications patients were currently using in order to identify any potential adverse effects and drug reactions for 16 of 16 patients in the sample (#1 through #16). Findings include: Record Review Patients #1 through #16 The Medication Profile located in the patients' records, listed the current medications the patients were taking. There was no documented evidence to verify the comprehensive assessment included a review of all medications the patients were currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Interview On 7/25/08, the Quality Assurance registered nurse had identified these findings.	G 337	by the agency. The remaining patients identified on the roster have been discharge. The agency has instituted a new medication profile and medication side effects/instruction guide (Attachment *Other patients having the potential to be affected by the deficient practice.* All patients have the potential to be affected by this deficient practice. Measures or systemic changes instituted to ensure the deficient practice will not recur. The new medication profile specifically identifies if duplicate/ineffective drug therapies or potential contraindications as well as an area to identif5' potential side effects of the medication. The agency will supplement this form with a four (4) page medication side effects/instruction guide (Attachment M-5). A copy of the medication profile and the instruction guide will remain in the patient's home. The medication profile will be reviewed at each visit and update when new medications are added or medications are changed. The medication instruction sheet will be personalized for each patient by circling or highlighting the appropriate (SEE ATTACHED)	

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